



Employer Group Application

Western
Health
Advantage



*within reach,
beyond expectation*

Employer Group Application

Becomes part of the Group Agreement



Western Health Advantage

Company name			Group # (office use)		
Street address (physical address only)			Subgroup/class (office use)		
City	State	Zip	Requested effective date		
Billing/mailling address			County	Federal Employer I.D. #	
City	State	Zip	Type of industry		
Chief Executive Officer or Proprietor			Years in business		
Benefits Administrator/title			Phone	Fax	
E-mail and website address			Other language considerations		
Does the employer offer other coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the carriers, and type of coverage offered and premium for each option.			Previous carrier(s): <input type="checkbox"/> None Please list previous carriers and type of coverage, if applicable.		
1.	<input type="checkbox"/> HMO	<input type="checkbox"/> PPO	1.	<input type="checkbox"/> HMO	<input type="checkbox"/> PPO
2.	<input type="checkbox"/> HMO	<input type="checkbox"/> PPO	2.	<input type="checkbox"/> HMO	<input type="checkbox"/> PPO

Are all employees eligible for this plan covered by Worker's Compensation?
 Yes No – please explain: _____

Are your benefits subject to ERISA regulation? Yes No

TYPE OF ORGANIZATION Sole Proprietorship Corporation Partnership Other _____

ELIGIBLE EMPLOYEES

- Total number of employees _____
- Number of part-time, seasonal and temporary employees _____
- Number of eligible employees (subtract line 2 from line 1) _____
- Number of employees declining (complete waiver) or covered elsewhere _____
- Total employees enrolling in WHA (subtract line 4 from line 3) _____

ELIGIBLE EMPLOYEES

- Sole Proprietor
- 2 – 19
- 20 – 50
- 51+

CONTINUATION COVERAGE

Employer is responsible for contacting current carrier to obtain name(s) and address(es) of current COBRA participants.

Please indicate number of current COBRA participants _____ (attach list)

Is employer required to offer: Cal-COBRA Federal COBRA

BENEFITS (multiple plans are available to groups with three or more employees enrolled)

HMO Medical Plan(s)					Prescription Rider(s)	
Premier	<input type="checkbox"/> 10	<input type="checkbox"/> 15	<input type="checkbox"/> 20	<input type="checkbox"/> 40	<input type="checkbox"/> RxH	Medicare Primary Plan <input type="checkbox"/> Premier Medicare Supplement 10 (available to groups under 20 total employees)
Advantage	<input type="checkbox"/> 15-30	<input type="checkbox"/> 420	<input type="checkbox"/> 70	<input type="checkbox"/> 40	<input type="checkbox"/> RxJ	
Western (RxW only)	<input type="checkbox"/> 4010	<input type="checkbox"/> 2025	<input type="checkbox"/> 4025		<input type="checkbox"/> RxW	
HSA-compatible (Rx included)	<input type="checkbox"/> 1800	<input type="checkbox"/> 2800B	<input type="checkbox"/> 2800			
Premier	<input type="checkbox"/> 10	<input type="checkbox"/> 15	<input type="checkbox"/> 20	<input type="checkbox"/> 40	<input type="checkbox"/> RxH	Optional Rider(s) <input type="checkbox"/> Infertility Rider (available to groups over 20 eligible employees) Vision Rider (minimum 2 employees enrolled) <input type="checkbox"/> Eyewear Only <input type="checkbox"/> \$0 Copay <input type="checkbox"/> Full-Service <input type="checkbox"/> \$10 Copay <input type="checkbox"/> Healthyroads Coaching Program (minimum 2 employees enrolled)
Advantage	<input type="checkbox"/> 15-30	<input type="checkbox"/> 420	<input type="checkbox"/> 70	<input type="checkbox"/> 40	<input type="checkbox"/> RxJ	
Western (RxW only)	<input type="checkbox"/> 4010	<input type="checkbox"/> 2025	<input type="checkbox"/> 4025		<input type="checkbox"/> RxW	
HSA-compatible (Rx included)	<input type="checkbox"/> 1800	<input type="checkbox"/> 2800B	<input type="checkbox"/> 2800			
Premier	<input type="checkbox"/> 10	<input type="checkbox"/> 15	<input type="checkbox"/> 20	<input type="checkbox"/> 40	<input type="checkbox"/> RxH	
Advantage	<input type="checkbox"/> 15-30	<input type="checkbox"/> 420	<input type="checkbox"/> 70	<input type="checkbox"/> 40	<input type="checkbox"/> RxJ	
Western (RxW only)	<input type="checkbox"/> 4010	<input type="checkbox"/> 2025	<input type="checkbox"/> 4025		<input type="checkbox"/> RxW	
HSA-compatible (Rx included)	<input type="checkbox"/> 1800	<input type="checkbox"/> 2800B	<input type="checkbox"/> 2800			

Rates (attach copy of rate quote)

Age-rated

Composite – Tier 1 2 3 4

Office use only – for small group

RAF _____ RAF effective date _____

Enrollment / Payment Provisions



Western Health Advantage

GROUP NAME _____

GROUP NUMBER (office use) _____

ELIGIBILITY REQUIREMENTS

A bona fide employee/employer relationship must be maintained; that is, the employer must continually compensate the individual in the form of annual, monthly, weekly or hourly wage. Further, the employer and employee must maintain an employment relationship pursuant to which the employer pays those payroll costs (e.g. FICA, FUI, SUI, and Worker's Compensation) normally associated with a bona fide employer/employee relationship.

Eligible employees shall be active, full-time employees who work at least _____ hours per week (minimum of 20 hours)

CATEGORIES OF ELIGIBILITY

- Dependents** (spouse, CA registered domestic partner, child(ren) under 19 or up to age 24 if full-time student)
- Domestic Partners** (non-registered domestic partner, subject to approval — attach notarized Declaration of Domestic Partner Form with enrollment form)
- Retired Beneficiaries** (subject to approval)

COMMENCEMENT OF COVERAGE

- 1st month following Date of Hire
- 1st month following _____ month(s) from Date of Hire
- Other (attach description)

Note:

All terminations are effective the last day of the month in which employee ceases to be eligible under group eligibility provisions.

EMPLOYER CONTRIBUTION

- Employee Only** \$ _____ or _____ % of Rate
- Dependents** \$ _____ or _____ % of Rate

Note:

- **Employer must contribute a minimum of 50% of Employee Only premium.**
- **If age grid rates are used, employer contribution must be percentage-based.**

BROKER INFORMATION

- Existing Broker
- New Broker
(must complete Agent Agreement)

Broker name: _____ Phone: _____

Agency: _____ Fax: _____

Broker #: _____ E-mail: _____

Commission: Small group standard Flat ____% Other: _____ License #: _____

COMMENTS

PREPAYMENT REQUIREMENTS

Monthly prepayment fees are due and payable in full on the first day of each calendar month for which services are provided. If payment is not received from the employer, coverage for enrollees will be terminated on the last day of the month for which prepayment fees were received. Any other payment arrangements require prior approval.

EMPLOYER STATEMENT

We wish to enroll our organization as an employer group with Western Health Advantage.

We understand the eligibility rules and prepayment fee requirements.

Employer contribution and employee participation requirements have been explained and we understand that these must be maintained in order for the account to remain eligible for coverage.

To the best of our knowledge and behalf, the foregoing statements are true and complete. This application shall be the basis for the issuance of coverage under the Group Service Agreement and shall become a part thereof. WHA reserves the right to terminate group coverage or the coverage for any individual member if the employer or individual member has made any material misrepresentation.

Signature _____ Date _____

Print name _____ Title _____

BROKER STATEMENT

I certify that: all the information contained in this application is correct to the best of my knowledge; the applicant is a bona fide business establishment; participation requirements have been met; and all coverages, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer. I recommend that such coverage be offered and know of no reason why coverage should be declined.

Broker signature _____ Date _____

WHA APPROVAL

Sales approval _____ Date _____ Account Executive _____ Date _____

Published: January 2010

Employer New Business Checklist

All relevant documentation must be submitted to WHA by the 5th of the month:

- Employer Group Application (to be completed by employer)
- Enrollment forms: _____ # of forms
- Waiver forms for eligible employees who decline group health coverage for themselves or their dependents
- Copy of rate quote
- A deposit in the amount of one month's premium
- EFT Authorization Form (required for Sole Proprietors)

Return Materials to:

Western Health Advantage
2349 Gateway Oaks Drive
Suite 100
Sacramento, CA 95833

916.563.3198 local
916.568.1338 fax
westernhealth.com

Applicable group supporting documentation must accompany group application:

- Sole Proprietors, Owners or Partners: Schedule C showing annual gross income (or Schedule K for Partnerships) and *WHA Sole Proprietor/Owner/Partner Statement*. Note: must be a full-time business engaged in producing adequate income (amount specified by WHA).
- Employer groups of 2 or more: copy of most recent Quarterly Wage and Withholding Report (DE-6)
- Employer groups of 51 or more: *WHA Group Underwriting Questionnaire*

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